U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of ROSARIO R. JUAREZ and GENERAL SERVICES ADMINISTRATION, ROUGH & READY ISLAND, Stockton, CA

Docket No. 00-2168; Submitted on the Record;
Issued July 5, 2001

DECISION and ORDER

Before WILLIE T.C. THOMAS, BRADLEY T. KNOTT,
PRISCILLA ANNE SCHWAB

The issue is whether appellant sustained more than a 23 percent impairment of the right lower extremity, for which he received a schedule award.

The Office of Workers' Compensation Programs accepted that on May 29, 1996 appellant, then a 50-year-old custodial worker, fell off a cooling tub while cleaning overhead pipes and sustained a torn medial meniscus and soft tissue injury to the popliteal surface.[1] On March 25, 1997 Dr. Mohinder S. Nijjar, an attending Board-certified orthopedic surgeon, performed an "[a]rthroscopic partial medial meniscectomy and debridement of the right knee and excision of the popliteal cyst in the right knee."

In a September 28, 1999 report, Dr. Roland H. Winter, an attending Board-certified orthopedic surgeon, related appellant's complaints of "increased pain and swelling in the knee especially with activity" found that he was unable to "run, walk fast or climb stairs consecutively." Dr. Winter noted findings on examination of "pain about the medial aspect of the right knee," 95 degrees of flexion out of 125, muscular atrophy of 2.5 cm in the quadriceps and 7 cm in the gastrocnemius and "moderate degenerative changes" by x-ray.

[1] A February 5, 1997 magnetic resonance imaging scan of appellant's right knee showed "[p]osterior horn, medial meniscus degeneration with complex tear," [j]oint effusion" and an "[e]xtremely large multiloculated Baker's cyst, measuring greater than 5.0 cm [centimeters] in length and between 2.0 and 3.0 cm in diameter." Appellant submitted progress notes dated May 30, 1996 to February 11, 1997 from attending orthopedists Drs. David Allen, Michael Gibson and Mohinder S. Nijjar, indicating that appellant's knee had not improved and would require surgery.

Referring to the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (4th ed.) (A.M.A., *Guides*), he found that according to Table 37, page 77,[2] atrophy of 2.5 cm in the right thigh equaled a "lower extremity impairment of 8 to 13 percent," while the 0.7 cm atrophy of the calf did "not translate into any impairment." Referring to Table 41, page 78,[3] Dr. Winter determined that a limitation of flexion to 95 degrees equaled a 10 percent impairment of the lower extremity. Using the Combined Values Chart, he calculated a 20 percent impairment of the right lower extremity.[4] Dr. Winter opined that appellant had reached maximum medical improvement.

In a November 2, 1999 report, an Office medical adviser reviewed the medical record and Dr. Winter's September 28, 1999 report and noted that appellant had reached maximum medical improvement. The Office medical adviser concurred with Dr. Winter that the limitation of flexion to 95 out of 125 degrees represented a 10 percent impairment of the lower extremity according to Table 41, page 78. The medical adviser found that the 2.5 centimeter thigh atrophy equaled a moderate or 11 percent impairment of the lower extremity. The medical adviser also provided an impairment due to pain of 4 percent according to Chapter 3, "pain and/or altered sensation that may interfere with activity or a 60 percent grade of a maximal 7 percent (femoral nerve)…." Using the Combined Values Chart, "4 percent for pain factors, combined with the 11 percent for thigh atrophy, combined with the 10 percent for loss of motion would be equivalent to a 23 percent impairment of the right lower extremity…."[5]

By decision dated February 3, 2000, the Office awarded appellant a schedule award for a 23 percent permanent impairment of the right leg, based on the Office medical adviser's November 2, 1999 report.[6]

[2] Table 37, page 77 is entitled "Impairments from Leg Muscle Atrophy." According to this table, a difference in circumference of between 2 and 2.9 centimeters is classified as a "moderate" impairment, representing an "8 to 13 percent" impairment of the lower extremity.

[3] Table 41, page 78, entitled "Knee Impairments," rates flexion of more than 80 degrees but less than 110 degrees out of 125 as "mild," equivalent to a 10 percent impairment of the lower extremity.

[4] Using the Combined Values Chart appearing on pages 322 and 323 of the A.M.A., *Guides*, combining the 13 and 10 percent impairments actually results in a 22 percent impairment. However, as the Office relied on the Office medical adviser's determination of a 23 percent permanent impairment, Dr. Winter's error is moot.

[5] The Office medical adviser combined the 11 and 10 percent impairments to arrive at 20 percent, then combined the 20 percent figure with the 4 percent impairment due to pain to arrive at a final 23 percent impairment rating. The Office medical adviser also noted an alternative method of calculation based on the partial meniscectomy that would equate to a 7 percent impairment of the right leg, but recommended that the Office adopt the 23 percent impairment rating as it more accurately described the elements of appellant's impairment.

[6] The period of the award ran from September 18, 1998 to December 25, 1999, paid in a single check in the amount of $31,584.02. The record also contains a June 12, 2000 preliminary notice of overpayment and documents related to this issue. However, there is no final decision of record regarding any overpayment of compensation. Therefore, this issue is not before the Board.

The Board finds that appellant has not established that he sustained more than a 23 percent permanent impairment of the right lower extremity, for which he received a schedule award.

The schedule award provisions of the Federal Employees' Compensation Act[7] and its implementing regulations[8] set forth the number of weeks of compensation to be paid for permanent loss or loss of use of the members of the body listed in the schedule. However, the Act does not specify the manner in which the percentage of loss of a member shall be determined. The method used in making such determination is a matter which rests in the sound discretion of the Office.[9] The Board has held, however, that for consistent results and to ensure equal justice under the law to all claimants, good administrative practice necessitate the use of a single set of tables so that there may be uniform standards applicable to all claimants. The Office has adopted the A.M.A., *Guides* as an appropriate standard for evaluating schedule losses and to ensure equal justice for all claimants.[10] The Board has concurred with the adoption of these A.M.A., *Guides*.

The standards for evaluating the percentage of impairment of extremities under the A.M.A., *Guides* are based primarily on loss of range of motion. In determining the extent of loss of motion, the specific functional impairments, such as loss of flexion or extension, should be itemized and stated in terms of percentage loss of use of the member in accordance with the tables in the A.M.A., *Guides*.[11] All factors that prevent a limb from functioning normally should be considered, such as pain and weakness, together with loss of motion, in evaluating the degree of permanent impairment. This was correctly done by the Office medical adviser in appellant's case.

In his November 2, 1999 report, the Office medical adviser reviewed the medical record, in particular the September 28, 1999 report from Dr. Winter, an attending orthopedic surgeon. The Office medical adviser then provided impairment ratings according to the A.M.A., *Guides* due to pain, atrophy and loss of range of motion based on these findings. The Office medical adviser calculated a 4 percent impairment of the femoral nerve based on the activity limitations appellant reported due to pain. The medical adviser then determined that limitation of flexion to 95 degrees out of 125 equaled a 10 percent impairment. Finally, the Office medical adviser determined that the 2.5 centimeter atrophy of the thigh musculature represented an 11 percent impairment of the right lower extremity. The Office medical adviser then used the Combined Values Chart to arrive at a 23 percent impairment of the right lower extremity.

[7] 5 U.S.C. §§ 8107-8109.

[8] 20 C.F.R. § 10.404.

[9] *Danniel C. Goings*, 37 ECAB 781 (1986); *Richard Beggs*, 28 ECAB 387 (1977).

[10] FECA Bulletin No. 89-30 (issued September 28, 1990).

[11] *William F. Simmons*, 31 ECAB 1448 (1980); *Richard A. Ehrlich*, 20 ECAB 246, 249 (1969) and cases cited therein.

The Board finds that the Office medical adviser accurately applied the appropriate tables and grading schemes of the A.M.A., *Guides* to Dr. Winter's findings regarding pain, loss of motion and atrophy to arrive at the 23 percent impairment rating. The Board notes that appellant has not provided any medical evidence, referring to the appropriate sections of the A.M.A., *Guides,* that documents more than a 23 percent permanent impairment of the right leg. Consequently, the Board finds that appellant sustained a 23 percent impairment of the right lower extremity due to sequelae of the May 29, 1996 fall.

The February 3, 2000 decision of the Office of Workers' Compensation Programs is hereby affirmed.

Dated, Washington, DC
July 5, 2001

Willie T.C. Thomas
Member

Bradley T. Knott
Alternate Member

Priscilla Anne Schwab
+ Alternate Member